

		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0043463</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>BENTON HEALTHCARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>1409 NORTH MAIN STREET</u> <u>BENTON</u> <u>62812</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>FRANKLIN</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____	
Telephone Number: <u>(618) 435-2712</u> Fax # <u>(618) 435-2105</u>		(Type or Print Name) <u>LARRY BONDS</u>	
IDPA ID Number: <u>830320180031</u>		(Title) <u>PRESIDENT</u>	
Date of Initial License for Current Owners: <u>02/07/98</u>		(Signed) _____ (Date) _____	
Type of Ownership:		Paid Preparer (Print Name and Title) <u>JEFFREY E. BOLAND, DIRECTOR</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>ZA CONSULTING, LLC</u> <u>305 NORTH FRONT STREET, HARRISBURG, PA 17101</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(717) 213-3125</u> Fax # <u>(717) 233-4633</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>JEFFREY E. BOLAND</u> Telephone Number: <u>(717) 213-3125</u>			

Facility Name & ID Number BENTON HEALTHCARE CENTER# 0043463 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>71</u>	Intermediate (ICF)	<u>71</u>	<u>25,986</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>71</u>	TOTALS	<u>71</u>	<u>25,986</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>20,609</u>	<u>4,381</u>	<u>82</u>	<u>25,072</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,609</u>	<u>4,381</u>	<u>82</u>	<u>25,072</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 96.48%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 02/07/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 02/07/98 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number BENTON HEALTHCARE CENTER # 0043463 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	89,880	8,188	4,952	103,020		103,020	(615)	102,405		1
2	Food Purchase		71,927		71,927		71,927		71,927		2
3	Housekeeping	51,778	6,347	90	58,215		58,215		58,215		3
4	Laundry	28,846	6,067	994	35,907		35,907		35,907		4
5	Heat and Other Utilities			52,666	52,666		52,666		52,666		5
6	Maintenance	17,013	7,234	19,404	43,651		43,651		43,651		6
7	Other (specify):*										7
8	TOTAL General Services	187,517	99,763	78,106	365,386		365,386	(615)	364,771		8
	B. Health Care and Programs										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	504,874	32,392	39,380	576,646	541	577,187	4,551	581,738		10
10a	Therapy		593	5,627	6,220		6,220		6,220		10a
11	Activities	21,339	788	1,404	23,531		23,531		23,531		11
12	Social Services	20,019		1,706	21,725		21,725	55	21,780		12
13	Nurse Aide Training			541	541	(541)					13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	546,232	33,773	58,258	638,263		638,263	4,606	642,869		16
	C. General Administration										
17	Administrative			71,122	71,122		71,122	16,098	87,220		17
18	Directors Fees										18
19	Professional Services			229	229		229	32,357	32,586		19
20	Dues, Fees, Subscriptions & Promotions			13,111	13,111		13,111	(7,535)	5,576		20
21	Clerical & General Office Expenses	11,611	8,781	31,183	51,575		51,575	38,529	90,104		21
22	Employee Benefits & Payroll Taxes			91,074	91,074		91,074	70,561	161,635		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,766	1,766		1,766	3,563	5,329		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			26,453	26,453		26,453	21,542	47,995		26
27	Other (specify):*										27
28	TOTAL General Administration	11,611	8,781	234,938	255,330		255,330	175,115	430,445		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	745,360	142,317	371,302	1,258,979		1,258,979	179,106	1,438,085		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			45,116	45,116		45,116		45,116			30
31	Amortization of Pre-Op. & Org.			128,310	128,310		128,310	(122,804)	5,506			31
32	Interest			190,875	190,875		190,875		190,875			32
33	Real Estate Taxes			13,085	13,085		13,085		13,085			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			8,987	8,987		8,987		8,987			35
36	Other (specify):* MTG GUARANTEE			36,038	36,038		36,038		36,038			36
37	TOTAL Ownership			422,411	422,411		422,411	(122,804)	299,607			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,853	1,698	9,551		9,551		9,551			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,980	38,980		38,980		38,980			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		7,853	40,678	48,531		48,531		48,531			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	745,360	150,170	834,391	1,729,921		1,729,921	56,302	1,786,223			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(615)	1		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment	(548)	21		19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(7,535)	20		25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule	(134,397)	VAR		29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (143,095)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	199,397	VAR	34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 199,397		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 56,302		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
BENTON HEALTHCARE CENTER

Page 5A

Report Period Beginning: ID# 0043463
Ending: 01/01/00
12/31/00

NON-ALLOWABLE EXPENSES			Sch. V Line	
		Amount	Reference	
1	BANK CHARGES	\$ (20)	21	1
2	EXTRAORDINARY ITEMS	(5,013)	21	2
3	AMORTIZATION - GOODWILL	(122,804)	31	3
4	PRIOR YEAR EXPENSE	(6,560)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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88				88
89				89
90	Total	(134,397)		90

Summary A

12/31/00

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BENTON HEALTHCARE CENTER# 0043463

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(122,804)	0	0	0	0	0	0	0	0	0	0	(122,804)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(122,804)	0	0	0	0	0	0	0	0	0	0	(122,804)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(143,095)	26,283	173,114	0	0	0	0	0	0	0	0	56,302	45

Facility Name & ID Number **BENTON HEALTHCARE CENTER** # **0043463** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		EDEN & ASSOCIATE	WILSON, WY	CONSULTING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	10 Contract Services - RN	\$	Senior Living Properties, LLC	100.00%	\$ 484	\$ 484 1
2	V	10 Contract Services - RN		Senior Living Properties, LLC	100.00%	1,859	1,859 2
3	V	10 Contract Services - RN		Senior Living Properties, LLC	100.00%	2,208	2,208 3
4	V	12 Social Services Consultant	1,706	Senior Living Properties, LLC	100.00%	1,761	55 4
5	V	17 Contract Services - Business Office	21,009	Senior Living Properties, LLC	100.00%	31,588	10,579 5
6	V	17 Contract Services - Administrator	50,113	Senior Living Properties, LLC	100.00%	55,632	5,519 6
7	V	24 Travel	1,523	Senior Living Properties, LLC	100.00%	4,921	3,398 7
8	V	21 Business Meals	317	Senior Living Properties, LLC	100.00%	622	305 8
9	V	24 Seminars	70	Senior Living Properties, LLC	100.00%	235	165 9
10	V	21 Office Supplies	3,429	Senior Living Properties, LLC	100.00%	3,881	452 10
11	V	21 Supplies	1,955	Senior Living Properties, LLC	100.00%	2,042	87 11
12	V	21 Postage	1,430	Senior Living Properties, LLC	100.00%	1,447	17 12
13	V	21 Telephone	16,340	Senior Living Properties, LLC	100.00%	17,495	1,155 13
14	Total		\$ 97,892			\$ 124,175	\$ * 26,283 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BENTON HEALTHCARE CENTER

0043463

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21 EDP Services	\$	Senior Living Properties, LLC	100.00%	\$ 5,124	\$ 5,124	15
16	V	19 Legal Fees	228	Senior Living Properties, LLC	100.00%	10,923	10,695	16
17	V	19 Accounting Fees		Senior Living Properties, LLC	100.00%	21,144	21,144	17
18	V	26 Insurance - General Liability	23,826	Senior Living Properties, LLC	100.00%	27,650	3,824	18
19	V	26 Insurance - Property & Contents	2,527	Senior Living Properties, LLC	100.00%	20,087	17,560	19
20	V	26 Insurance - Other	99	Senior Living Properties, LLC	100.00%	257	158	20
21	V	22 Workers Compensation Claims	27,174	Senior Living Properties, LLC	100.00%	31,961	4,787	21
22	V	22 Health & Dental Insurance		Senior Living Properties, LLC	100.00%	16,774	16,774	22
23	V	21 Management Fees		Senior Living Properties, LLC	100.00%	24,970	24,970	23
24	V	19 Legal Fees		Senior Living Properties, LLC	100.00%	518	518	24
25	V	22 Workers Compensation Claims		Senior Living Properties, LLC	100.00%	49,000	49,000	25
26	V	21 Management Fees		Senior Living Properties, LLC	100.00%	18,560	18,560	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 53,854			\$ 226,968	\$ * 173,114	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **BENTON HEALTHCARE CENTER** # **0043463** Report Period Beginning: **01/01/00** Ending: **12/31/00**

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BENTON HEALTHCARE CENTER # 0043463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Senior Living Properties, LLC
 Street Address 3395 North Pines Drive, Suite 102
 City / State / Zip Code Wilson, Wyoming 83014
 Phone Number (307) 739-1209
 Fax Number (307) 739-1217

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Contract Services - RN	Resident Days (IL only)	675,434	31	\$ 13,034	\$	25,072	\$ 484	1
2	10	Contract Services - RN	Resident Days (IL only)	675,434	31	50,078		25,072	1,859	2
3	10	Contract Services - RN	Resident Days (IL only)	675,434	31	59,476		25,072	2,208	3
4	12	Social Services Consultant	Resident Days (IL only)	675,434	31	1,475		25,072	55	4
5	17	Contract Services - Business Office	Resident Days (Total)	1,728,555	88	729,382		25,072	10,579	5
6	17	Contract Services - Administrator	Resident Days (IL only)	675,434	31	148,670		25,072	5,519	6
7	24	Travel	Resident Days (IL only)	675,434	31	91,552		25,072	3,398	7
8	21	Business Meals	Resident Days (IL only)	675,434	31	8,225		25,072	305	8
9	24	Seminars	Resident Days (IL only)	675,434	31	4,452		25,072	165	9
10	21	Office Supplies	Resident Days (IL only)	675,434	31	12,185		25,072	452	10
11	21	Supplies	Resident Days (IL only)	675,434	31	2,350		25,072	87	11
12	21	Postage	Resident Days (IL only)	675,434	31	466		25,072	17	12
13	21	Telephone	Resident Days (IL only)	675,434	31	31,125		25,072	1,155	13
14	21	EDP Services	Resident Days (IL only)	675,434	31	138,040		25,072	5,124	14
15	19	Legal Fees	Resident Days (Total)	1,728,555	88	737,379		25,072	10,695	15
16	19	Accounting Fees	Resident Days (Total)	1,728,555	88	1,457,713		25,072	21,144	16
17	26	Insurance - General Liability	Resident Days (Total)	1,728,555	88	263,635		25,072	3,824	17
18	26	Insurance - Property & Contents	Resident Days (Total)	1,728,555	88	1,210,642		25,072	17,560	18
19	26	Insurance - Other	Resident Days (Total)	1,728,555	88	10,924		25,072	158	19
20	22	Workers Compensation Claims	Resident Days (Total)	1,728,555	88	330,015		25,072	4,787	20
21	22	Health & Dental Insurance	Resident Days (Total)	1,728,555	88	1,156,469		25,072	16,774	21
22	21	Management Fees	Resident Days (Total)	1,728,555	88	1,721,509		25,072	24,970	22
23	19	Legal Fees	Resident Days (IL only)	675,434	31	13,948		25,072	518	23
24	22	Workers Compensation Claims	Resident Days (IL only)	675,434	31	1,320,062		25,072	49,000	24
25	TOTALS					\$ 9,512,806	\$		\$ 180,837	25

Facility Name & ID Number BENTON HEALTHCARE CENTER # 0043463 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Senior Living Properties, LLC
 Street Address 3395 North Pines Drive, Suite 102
 City / State / Zip Code Wilson, Wyoming 83014
 Phone Number (307) 739-1209
 Fax Number (307) 739-1217

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1	21	Management Fees	Resident Days (IL only)	675,434	31	\$ 500,000	\$ 25,072	\$ 18,560	1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$ 500,000	\$		\$ 18,560	25

Facility Name & ID Number **BENTON HEALTHCARE CENTER**# **0043463**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	GMAC COMMERCIAL MORT COR	X		ACQUISITION	\$13,666.00	02/06/98	\$	1,971,398	\$	1,845,449	02/01/08	0.6810	\$	133,450		1			
2	COMPLETE CARE SERVICES	X		ACQUISITION	\$7,277.00	02/06/98		87,230		87,230	02/06/08	0.0700		12,724		2			
3	SEE ATTACHMENT		X	ACQUISITION	\$7,277.00	02/06/98		87,230		87,230	02/06/08	0.0700		12,724		3			
4																4			
5																5			
	Working Capital																		
6	HEALTHCARE FINANCIAL PARTN	X		WORKING CAPITAL	NONE	02/06/98		47,953		37,053	DEMAND	PRIME + 2%		31,977		6			
7																7			
8																8			
9	TOTAL Facility Related				\$28,220.00		\$	2,193,811	\$	2,056,962			\$	190,875		9			
	B. Non-Facility Related*																		
10																10			
11																11			
12																12			
13																13			
14	TOTAL Non-Facility Related						\$		\$				\$			14			
15	TOTALS (line 9+line14)						\$	2,193,811	\$	2,056,962			\$	190,875		15			

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **BENTON HEALTHCARE CENTER**# **0043463**Report Period Beginning: **01/01/00**

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	8,057	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	12,935	2
3. Under or (over) accrual (line 2 minus line 1).	\$	4,878	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	8,207	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$0.00 For 19 2000 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	13,085	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	11,222	8		FOR OFF USE ONLY	
	1996	12,228	9			
	1997	12,846	10	13	FROM R. E. TAX STATEMENT FOR 1999	\$
	1998	13,030	11	14	PLUS APPEAL COST FROM LINE 5	\$
	1999	12,935	12	15	LESS REFUND FROM LINE 6	\$
				16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
22,200

B. General Construction Type:

Exterior
BRICK & BLOCK

Frame
MASONRY

Number of Stories
1

C.
Does the Operating Entity?

☒
(a) Own the Facility

☐
(b) Rent from a Related Organization.

☐
(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.
Does the Operating Entity?

☒
(a) Own the Equipment

☐
(b) Rent equipment from a Related Organization.

☐
(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐
YES

☒
NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	122,404	1998	\$ 26,000	1
2					2
3	TOTALS	122,404		\$ 26,000	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	71		1998	1968	\$ 690,547	\$ 23,018	30	\$ 23,018	\$	\$ 67,136	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DOORS		1998		7,272	485	15	485		1,131	9
10	REMODEL BATHROOM		1998		12,000	800	10	800		1,733	10
11											11
12	SIGNAGE		1998		464	46	20	46		120	12
13	INSTALL CARPET		1999		2,655	531	5	531		1,018	13
14	CLEAN OUT SEWERS		1999		1,327	133	10	133		254	14
15	INTERIOR REMODELING - BATHROOM		1999		5,896	393	15	393		688	15
16	WIRING, EXIT LIGHTS, INSPECTIONS		1999		1,111	18	20	18		79	16
17	COVEBASE FOR VINYL FLOORING		1999		654	65	10	65		87	17
18	AWNING		1999		4,523	302	15	302		377	18
19	INTERIOR REMODELING - BATHROOM		1999		7,820	521	15	521		652	19
20	INTERIOR REMODELING - BATHROOM		1999		19,415	1,294	15	1,294		1,618	20
21	INTERIOR REMODELING - BATHROOM		1999		700	47	15	47		58	21
22	EXIT LIGHTS		1999		1,111	111	10	111		212	22
23	POURED CONCRETE		1999		400	27	15	27		49	23
24	LANDSCAPING		1999		1,800	180	10	180		240	24
25	LANDSCAPING		1999		1,600	160	10	160		213	25
26	RESURFACE PARKING LOT		1999		1,250	156	8	156		195	26
27											27
28	ALARM		2000		3,936	87	15	87		87	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 764,481	\$ 28,374		\$ 28,374	\$	\$ 75,947	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 110,438	\$ 16,254	\$ 16,254		Various	\$ 42,378	37
38	Current Year Purchases	6,592	488	488		Various	488	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 117,030	\$ 16,742	\$ 16,742			\$ 42,866	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 907,511	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 45,116	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 45,116	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 118,813	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **NOT APPLICABLE**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ NOT APPLICABLE			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: **NOT APPLICABLE** *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☒ YES ☐ NO

16. Rental Amount for movable equipment: \$ **8,952** Description: **DISHWASHER - \$245, COPIER - \$8,658, SCAFFOLDING TRUCK - \$49**

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$

13. /2002 \$

14. /2003 \$

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ NOT APPLICABLE	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building,
please provide complete details on attached
schedule.

** This amount plus any amortization of lease
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1					
2	Licensed Speech and Language Development Therapist		hrs							2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist		hrs							4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy	39.3	# of prescripts				269		269	9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Exceptional Care Program									12					
13	Other (specify): ANCILLARY SUPPLI	39.2,39.3					9,282		9,282	13					
14	TOTAL			\$		\$	\$ 9,551		\$ 9,551	14					

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 3,235	\$	1
2	Cash-Patient Deposits	35,493		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 60,065)	220,024		3
4	Supply Inventory (priced at COST)	13,346		4
5	Short-Term Investments			5
6	Prepaid Insurance	(12,599)		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 259,499	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	26,000		13
14	Buildings, at Historical Cost	758,853		14
15	Leasehold Improvements, at Historical Cost	8,625		15
16	Equipment, at Historical Cost	114,033		16
17	Accumulated Depreciation (book methods)	(118,813)		17
18	Deferred Charges	1,089,159		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,877,857	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,137,356	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 91,358	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	35,493		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,207		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTER COMPANY	165,305		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 300,363	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,056,962		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,056,962	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,357,325	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (219,969)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,137,356	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (31,359)	1
2	Restatements (describe):		2
3	AUDIT ADJUSTMENTS	16,843	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (14,516)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(205,453)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (205,453)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (219,969)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,760,621	1
2	Discounts and Allowances for all Levels	(241,327)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,519,294	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	4,559	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,559	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	615	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 615	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,524,468	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	365,386	31
32	Health Care	638,263	32
33	General Administration	255,330	33
	B. Capital Expense		
34	Ownership	422,411	34
	C. Ancillary Expense		
35	Special Cost Centers	9,551	35
36	Provider Participation Fee	38,980	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,729,921	40
41	Income before Income Taxes (line 30 minus line 40)**	(205,453)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (205,453)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? EXTENDED If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number BENTON HEALTHCARE CENTER

0043463

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,351	8,576	97,974	11.42	3
4	Licensed Practical Nurses	7,289	8,504	81,058	9.53	4
5	Nurse Aides & Orderlies	34,774	40,570	279,606	6.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	885	1,032	14,359	13.91	9
10	Activity Assistants	852	993	6,980	7.03	10
11	Social Service Workers			20,019		11
12	Dietician					12
13	Food Service Supervisor	1,971	2,299	16,701	7.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,279	14,326	73,179	5.11	15
16	Dishwashers					16
17	Maintenance Workers	2,008	2,343	17,013	7.26	17
18	Housekeepers	7,514	8,766	51,778	5.91	18
19	Laundry	4,890	5,705	28,846	5.06	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	1,783	2,080	11,611	5.58	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	752	877	14,132	16.11	31
32	Other Health Care MDS/PT COORD.	3,155	3,681	32,104	8.72	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	85,503	99,753	\$ 745,360 *	\$ 7.47	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	\$ 3,328	1.3	35
36	Medical Director	MONTHLY	9,600	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	MONTHLY	5,627	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	MONTHLY	1,404	11.3	44
45	Social Service Consultant	MONTHLY	1,706	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 21,665		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

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BENTON HEALTHCARE CENTER

STATE OF ILLINOIS

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$

B. Administrative - Other

Description	Amount
CONTRACT ADMINISTRATOR	\$ 50,112
CONTRACT BUSINESS OFFICE MANAGER	21,010
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	\$ 71,122

C. Professional Services

Vendor/Payee	Type	Amount
VARIOUS	LEGAL	\$ 229
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$ 229

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 80,962
Unemployment Compensation Insurance	12,433
FICA Taxes	51,466
Employee Health Insurance	16,774
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	\$ 161,635

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$
Advertising: Employee Recruitment	4,575
Health Care Worker Background Check (Indicate # of checks performed)	578
ADVERTISING - PUBLIC RELATIONS	7,535
PROFESSIONAL DUES/LICENSES	423
Less: Public Relations Expense	(7,535)
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,576

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	4,921
Seminar Expense	408
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 5,329

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 12
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,252 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation. _____
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 38,980
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation. _____
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 615
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? IMMATERIAL
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NO - MINOR
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.